



MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

PART I: GENERAL INFORMATION

Requestor Name and Address: VISTA MEDICAL CENTER HOSPITAL 4301 VISTA RD PASADENA TX 77504	MFDR Tracking #: M4-06-7601-01 DWC Claim #: Injured Employee:
Respondent Name and Carrier's Austin Representative Box #: ST PAUL FIRE & MARINE INSURANCE CO Box #: 05	Date of Injury: Employer Name: Insurance Carrier #:

PART II: REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "The amount the Carrier paid Vista Medical Center for the services provided in this case was not fair and reasonable, and therefore, not in compliance with the applicable statutes and regulations. Vista Medical Center Hospital charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other carriers and the amount of reimbursement received for these same or similar services. The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract."

Amount in Dispute: \$13,995.93

PART III: RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: No position statement was provided in carrier response.

Response Submitted by: Travelers, PO Box 42927, Houston, TX 77242

PART IV: SUMMARY OF FINDINGS

Date(s) of Service	Denial Code(s)	Disputed Service	Amount in Dispute	Amount Due
10/10/2005	17, 878, INCL 97, DOP W10	Outpatient Surgery	\$6,354.39	\$0.00
11/21/2005	INCL 97, GL10 89, DOP W10, PYMT W10, Z014 97, Z029 42	Outpatient Surgery	\$7,641.54	\$0.00
			Total Due:	\$0.00

PART V: REVIEW OF SUMMARY, METHODOLOGY AND EXPLANATION

Texas Labor Code §413.011(a-d), titled *Reimbursement Policies and Guidelines*, and Division rule at 28 Texas Administrative Code §134.1, titled *Use of the Fee Guidelines*, effective May 16, 2002 set out the reimbursement guidelines.

This request for medical fee dispute resolution was received by the Division on August 16, 2006. Pursuant to Division rule at 28 TAC §133.307(g)(3), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, the Division notified the requestor on August 23, 2006 to send additional documentation relevant to the fee dispute as set forth in the rule.

- For the services involved in this dispute, the respondent reduced or denied payment with reason codes:
 - 17 – PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE. ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE.
 - 878 – IN ORDER TO CONSIDER THE CHARGE, PLEASE FORWARD THE PROCEDURE REPORT AND/OR NOTES ALONG WITH THIS ORIGINAL.
 - INCL 97 - PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. IF

REDUCTION, THEN PROCESSED ACCORDING TO THE TEXAS FEE GUIDELINES.

- DOP W10 – NO MAXIMUM ALLOWABLE DEFINED BY FEE GUIDELINE. REDUCED TO FAIR & REASONABLE. NO MAR HAS BEEN SET BY TWCC IN THE MEDICAL FEE GUIDELINE.
 - GL10 89 – PROFESSIONAL FEES REMOVED FROM CHARGES. SERVICES BILLED FOR RADIOLOGY, LAB, AND/OR PATHOLOGY BY A HOSPITAL SHOULD NORMALLY BE BILLED AT THE TC RATE.
 - PYMT W10 – NO MAXIMUM ALLOWABLE REIMBURSEMENT METHODOLOGY. REDUCED TO FAIR AND REASONABLE.
 - Z014 97 – PAYMENT IS INCLUDED IN THE ALLOWANCE FOR ANOTHER SERVICE/PROCEDURE. THIS PROCEDURE IS CONSIDERED INTEGRAL TO THE PRIMARY PROCEDURE BILLED.
 - Z029 42 – CHARGES EXCEED OUR FEE SCHEDULE OR MAXIMUM ALLOWABLE AMOUNT. BILL WAS REIMBURSED PER THE INSURANCE CARRIER'S FAIR AND REASONABLE ALLOWANCE.
2. Division rule at 28 TAC §134.401(b)(1)(B), effective August 1, 1997, 22 TexReg 6264, defines inpatient services as "Health care, as defined by the Texas Labor Code, §401.011(19), provided by an acute care hospital and rendered to a person who is admitted to an acute care hospital and whose length of stay exceeds 23 hours in any unit of the acute care hospital." Review of the submitted documentation supports that the claimant was admitted on 10/10/2005 for epidurogram and epidural lumbar steroid injection and discharged on that same day. Further review of the submitted documentation supports that the claimant was admitted again on 11/21/2005 for subsequent epidurogram and epidural lumbar steroid injection. The length of stay did not exceed 23 hours on either day; therefore, the Division concludes that the services in dispute do not meet the definition of inpatient services. The applicable rule for reimbursement of outpatient surgical services is Division rule at 28 TAC §134.1.
3. The respondent denied disputed services with reason code(s) 17 – "PAYMENT ADJUSTED BECAUSE REQUESTED INFORMATION WAS NOT PROVIDED OR WAS INSUFFICIENT/INCOMPLETE. ADDITIONAL INFORMATION IS SUPPLIED USING THE REMITTANCE ADVICE REMARKS CODES WHENEVER APPROPRIATE" and 878 – IN ORDER TO CONSIDER THE CHARGE, PLEASE FORWARD THE PROCEDURE REPORT AND/OR NOTES ALONG WITH THIS ORIGINAL." Division rule at 28 TAC §133.300(c) states that "Upon receipt, an insurance carrier shall evaluate each medical bill for completeness as defined in §133.1 of this title (relating to Definitions for Chapter 133, Benefits-- Medical Benefits). (1) Insurance carriers shall not return medical bills that are complete, unless the bill is a duplicate bill. (2) Within seven days after the day it receives an incomplete medical bill, an insurance carrier shall: (A) complete the bill by adding missing information already known to the insurance carrier; (B) contact the sender by telephone, facsimile, or electronic transmission to obtain the information necessary to make the bill complete and make the changes to the bill based on the information the sender provides; the insurance carrier shall document the name and telephone number of the person who supplied the information; or (C) if unable to complete the bill by adding missing information already known to the insurance carrier or contacting the sender, return the bill to the sender, in accordance with subsection (d) of this section." Division rule at 28 TAC §133.1(a)(3)(D) states that a complete medical bill "contains supporting documentation when such documentation is specifically required by Commission rules or guidelines, unless the required documentation was previously provided to the insurance carrier or its agents." No documentation was found to support that the carrier returned the bill to the provider as incomplete. Nor did the respondent support that the provider failed to submit documentation required by Commission rules or guidelines. The respondent did not present to requestor what information was not documented that was necessary to determine a fair and reasonable reimbursement for the services in dispute. This denial reason is not supported. The disputed services will therefore be reviewed per applicable rules and fee guidelines.
4. This dispute relates to services with reimbursement subject to the provisions of Division rule at 28 TAC §134.1, effective May 16, 2002, 27 TexReg 4047, which requires that "Reimbursement for services not identified in an established fee guideline shall be reimbursed at fair and reasonable rates as described in the Texas Workers' Compensation Act, §413.011 until such period that specific fee guidelines are established by the commission [now Division]."
5. Texas Labor Code §413.011(d) requires that fee guidelines must be fair and reasonable and designed to ensure the quality of medical care and to achieve effective medical cost control. The guidelines may not provide for payment of a fee in excess of the fee charged for similar treatment of an injured individual of an equivalent standard of living and paid by that individual or by someone acting on that individual's behalf. It further requires that the Division consider the increased security of payment afforded by the Act in establishing the fee guidelines.
6. Division rule at 28 TAC §133.307(g)(3)(D), effective January 1, 2003, 27 TexReg 12282, applicable to disputes filed on or after January 1, 2003, requires the requestor to provide "documentation that discusses, demonstrates, and justifies that the payment amount being sought is a fair and reasonable rate of reimbursement." Review of the submitted documentation finds that:
- The requestor's position statement asserts that "Vista Medical Center charges fair and reasonable rates for its services. Specifically, these rates are based upon a comparison of charges to other Carriers and the amount of reimbursement received for these same or similar services."
 - Documentation of the comparison of charges to other carriers was not presented for review.
 - Documentation of the amount of reimbursement received for these same or similar services was not presented for

review.

- The Division has previously found that “hospital charges are not a valid indicator of a hospital’s costs of providing services nor of what is being paid by other payors,” as stated in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, 22 TexReg 6276 (July 4, 1997). It further states that “Alternative methods of reimbursement were considered... and rejected because they use hospital charges as their basis and allow the hospitals to affect their reimbursement by inflating their charges...” 22 TexReg 6268-6269. Therefore, the use of a hospital’s “usual and customary” charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- In the alternative, the requestor asks to be reimbursed a minimum of 70% of billed charges, in support of which the requestor states that “The amount of reimbursement deemed to be fair and reasonable by Vista Medical Center Hospital is at a minimum, 70% of the billed charges. This is supported by the Focus managed care contract... This managed care contract exhibits that Vista Medical Center Hospital is requesting reimbursement that is designed to ensure quality medical care is provided to achieve effective medical cost control. It also shows numerous Insurance Carriers’ willingness to provide 70% reimbursement for Out-Patient Hospital setting medical services.”
- The requestor has provided select exhibit pages from the alleged managed care contract referenced above; however, a copy of the contract referenced in the position statement was not presented for review with this dispute.
- Review of the exhibit pages submitted by the requestor finds a schedule of charges, labeled exhibit “A”, dated 04/23/92, which states that “OUTPATIENT SERVICES: 101/401 PAY 70% OF BILLED CHARGES.”
- The requestor submitted a letter of clarification dated July 30, 1992 indicating a change in reimbursement to the above referenced contract, stating in part that “services rendered to eligible Beneficiaries will be considered at 80% of the usual and reasonable charge which is equal to the lesser of the actual charges billed by HCP; OR the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research Database.”
- The requestor submitted a fee schedule page, labeled exhibit A, dated effective August 1, 1992 which states, in part, that the provider shall receive “an amount equal to eighty percent (80%) of the Usual and Reasonable Charge for those Covered Services. For all purposes hereunder, the Usual and Reasonable Charge for such services shall be equal to the lesser of: (i) the actual charges billed by HCP for such services; or (ii) the eightieth (80th) percentile for charges for such services as set forth in the current Medical Data Research database.”
- No data or information was submitted from the Medical Data Research database to support the requested reimbursement.
- No documentation was presented by the requestor to support that the referenced contract was in effect at the time of the disputed services.
- The requestor’s position statement further asserts that “amounts paid to healthcare providers by third party payers are relevant to determining fair and reasonable workers’ compensation reimbursement. Further, the Division stated specifically that managed care contracts fulfill the requirements of Texas Labor Code § 413.011 as they are ‘relevant to what fair and reasonable reimbursement is,’ they are relevant to achieving cost control,’ they are relevant to ensuring access to quality care,’ and they are ‘highly reliable.’ See 22 TexReg 6272. Finally, managed care contracts were determined by the Division to be the best indication of a market price voluntarily negotiated for medical services.”
- While managed care contracts are relevant to determining a fair and reasonable reimbursement, the Division has previously found that a reimbursement methodology based upon payment of a percentage of a hospital’s billed charges does not produce an acceptable payment amount. This methodology was considered and rejected by the Division in the adoption preamble to the Division’s former *Acute Care Inpatient Hospital Fee Guideline*, which states at 22 Texas Register 6276 (July 4, 1997) that:

“A discount from billed charges was another method of reimbursement which was considered. Again, this method was found unacceptable because it leaves the ultimate reimbursement in the control of the hospital, thus defeating the statutory objective of effective cost control and the statutory standard not to pay more than for similar treatment of an injured individual of an equivalent standard of living. It also provides no incentive to contain medical costs, would be administratively burdensome for the Commission and system participants, and would require additional Commission resources.”

Therefore, a reimbursement amount that is calculated based upon a percentage of a hospital’s billed charges cannot be favorably considered when no other data or documentation was submitted to support that the payment amount being sought is a fair and reasonable reimbursement for the services in dispute.
- The requestor did not submit documentation to support that payment of the amount sought is a fair and reasonable rate of reimbursement for the services in this dispute.
- The requestor did not support that payment of the requested amount would satisfy the requirements of Division rule at 28 TAC §134.1.

The request for additional reimbursement is not supported. Thorough review of the documentation submitted by the requestor finds that the requestor has not demonstrated or justified that payment of the amount sought would be a fair and

reasonable rate of reimbursement for the services in dispute. Additional payment cannot be recommended.

7. The Division would like to emphasize that individual medical fee dispute outcomes rely upon the evidence presented by the requestor and respondent during dispute resolution, and the thorough review and consideration of that evidence. After thorough review and consideration of all the evidence presented by the parties to this dispute, it is determined that the submitted documentation does not support the reimbursement amount sought by the requestor. The Division concludes that this dispute was not filed in the form and manner prescribed under Division rules at 28 Texas Administrative Code §133.307(g)(3)(D). The Division further concludes that the requestor failed to support its position that additional reimbursement is due. As a result, the amount ordered is \$0.00.

PART VI: GENERAL PAYMENT POLICIES/REFERENCES

Texas Labor Code §413.011(a-d), §413.031 and §413.0311
28 Texas Administrative Code §133.307, §134.1, §133.300, and §133.1
Texas Government Code, Chapter 2001, Subchapter G

PART VII: DIVISION DECISION

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is not entitled to additional reimbursement for the services involved in this dispute.

DECISION:

_____	_____	06/24/11
Authorized Signature	Medical Fee Dispute Resolution Officer	Date

PART VIII: YOUR RIGHT TO REQUEST AN APPEAL

Either party to this medical fee dispute has a right to request an appeal. A request for hearing must be in writing and it must be received by the DWC Chief Clerk of Proceedings within **20** (twenty) days of your receipt of this decision. A request for hearing should be sent to: Chief Clerk of Proceedings, Texas Department of Insurance, Division of Workers Compensation, P.O. Box 17787, Austin, Texas, 78744. **Please include a copy of the Medical Fee Dispute Resolution Findings and Decision** together with other required information specified in Division rule at 28 TAC §148.3(c).

Under Texas Labor Code §413.0311, your appeal will be handled by a Division hearing under Title 28 Texas Administrative Code Chapter 142 Rules if the total amount sought does not exceed \$2,000. If the total amount sought exceeds \$2,000, a hearing will be conducted by the State Office of Administrative Hearings under Texas Labor Code §413.031.

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.